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News, tips, info, details, and ideas brought to you by the Clinical Center JCAHO Work Group

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Patient Safety Goals

National Patient Safety Goals, are you aware of them and what they mean to our practice? Many of these stem from the reports that we have heard in the media or from our own experience. Below you will see the JCAHO National Patient Safety Goals and how we at the Clinical have incorporated them into our practice.

1. **Improve the accuracy of patient identification:**

Whenever a medication is given, an invasive procedure performed or blood is administered the patient should be asked to give his/her name and date of birth. For those patients who are uncommunicative, verify this information with the armband, before each interaction.

For patients under going an invasive or surgical procedure, staff should use a "time out" to actively identify the patient and verify the procedure and site. The patient is not expected to participate in this time out but should be consulted prior to this check for identification.

2. **Improve the effectiveness of communication among caregivers:**

When verbal and telephone orders are given, the recipient should provide a complete read back of the orders. Use clear language such as speaking clearly and slowly repeating the numbers individually (i.e. one, six rather than sixteen) for verification by the prescriber. Have a second person listen to the verbal/telephone orders, if possible.

Use standardized and approved abbreviations and acronyms when placing orders. See the CC website http://www.cc.nih.gov/medbrd/abbreviations/index.html

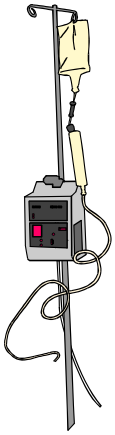
3. **Improve the safety of using high alert medications:**

All concentrated electrolytes (including potassium chloride and potassium phosphate) have been removed from patient care units. The Clinical Center has some standard medication concentrations and has begun the process of standardizing more medication concentrations, additional information will be forthcoming.

See other side→

4. **Eliminate wrong-site, wrong-patient and wrong-procedure surgery**

Use a pre-operative checklist to confirm proper site of surgery. Ensure that all documentation is correct and correlates with the marking made by staff for the site of surgery. Ensure that a consistent process for marking the surgical site is implemented and is carried out with each surgery. The mark should be visible after the surgical draping. Noting the non surgical site only is not acceptable.



5. **Improve the safety of using infusion pumps**

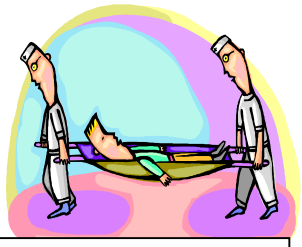
This goal applies to ambulatory pumps that have patient controlled (PCA) capacity, and does not apply to syringe or enteral pumps. Currently all of our pumps meet the free-flow protection requirements.

6. **Improve the effectiveness of clinical alarm systems**

Regular preventative maintenance should be performed on all alarm systems. Staff should ensure that alarms are audible during routine and high volume times in the area.

The ABCs of Patient Safety

Accountability is not always about a person.
Blame hides the truth about error.
Cultures must change
Document facts.
Error is our chance to see weakness in our systems and people.
Focus on prevention.
Gather evidence to support facts.
Hear when you listen.
Investigate cause.
Justice should include compassion, disclosure and compensation.
Knowledge must be shared.
Learning from others mistakes benefits all.
Make the effort to look beyond the obvious.
Nothing will change until you change it.
Opportunities for solutions are lost by blame.
Partner with patients and practitioners.
Question until you can no longer ask "why?".
Reporting error is suppressed by blame.
Systems are where practitioners practice.
Think about the blunt and sharp end.
Understand the role of accountability.
Value the patient perspective.
Why, Why, Why, Why, Why = root cause.



Safety First!

X-ray vision sees the deeper story.
You can make a difference.
Zeroing in on cause brings us one error closer to zero error.